Fields of Opportunities

STATE OF IOWA

THOMAS J. VILSACK
GOVERNOR

SALLY J. PEDERSON
LT. GOVERNOR

IOWA BOARD OF DENTAL EXAMINERS
CONSTANCE L. PRICE, EXECUTIVE DIRECTOR

INSTRUCTIONS FOR COMPLETING APPLICATION FOR IOWA DENTAL LICENSE

Enclosed is an application for an Iowa dental license. When completing this application, please be advised of the following.

- For specific license requirements, please refer to the Board's rules at Iowa Administrative Code 650—Chapter 11.
- Dentists licensed in the state of Iowa cannot administer deep sedation/general anesthesia or conscious sedation in the practice of dentistry unless a separate permit has been obtained from the Iowa Board of Dental Examiners. The application form for a permit is available on the Board website.
- All or part of the information provided on the application form may be considered a public record under Iowa Code chapter 22 and Iowa Administrative Code 650—Chapter 6. Information on misconduct, criminal history, and examination results is not subject to disclosure.
- Applications are issued administratively following review of a completed application and all required credentials, unless the application warrants referral to the license and examination committee, the full Board, or unless a personal appearance is required.
- The application fee is non-refundable.
- Applications are valid for only six months from the date of receipt. If a license has not been issued within six months, a new application will have to be submitted.
- **Failure to answer all questions completely or accurately, and/or omission or falsification of material facts may be cause for denial of your application or disciplinary action if you are subsequently licensed by the Board.**

To assist you in completing the application, please utilize the following checklist and be sure that you have responded to each item.

☐ Type or legibly print the application.

☐ Complete each question on the application. If not applicable, answer N/A.

☐ On page 1 of the application mark **licensure by examination** if you 1) are a recent graduate of an accredited dental school; and 2) have taken and successfully completed the Central Regional Dental Testing Service Examination (CRDTS) within five years of application, or the Western Regional Examining Board, Inc. (WREB) examination after January 1, 2001.

☐ On page 1 of the application, mark **licensure by credentials** if you 1) successfully completed an examination for licensure five or more years ago or took an exam other than CRDTS or WREB; and 2) have been licensed and practicing dentistry for a minimum period of three years. To be eligible for licensure by credentials, you must be a graduate of an accredited dental school and have a minimum of three years of active practice.

☐ Attach a practice reference for each practice location in the last three years. Attach at least one practice reference per location. If you are a new graduate, skip this step.

☐ For each "Yes" answer to questions 1 through 22 in section 8, you must provide a separate, signed statement giving full details, including date(s), location(s), action(s), organization(s) or parties involved, and specific reason(s).

☐ Attach a photograph to the application that is suitable for positive identification.

☐ The application must be notarized.

☐ Include the original or a notarized copy of your National Board card reflecting your scores.

☐ Applicants for licensure by examination: Include a copy of your scores from the CRDTS examination, or the WREB if taken after Jan. 1, 2001. If you have taken a clinical examination more than once, you must submit scores from each examination.

☐ After you have submitted your application for licensure to the Board office, the Board will send you authorization to sit for the Jurisprudence Examination, as well as a list of testing sites. Then, take and successfully complete the Iowa Jurisprudence Examination, which is based on information contained in Iowa Code chapters 147, 153, 272C, and all chapters of 650 Iowa Administrative Code. To study for the exam on the Board website at www.state.ia.us/dentalboard, visit the link under Rules and view the Code of Iowa and Board rules. To take the examination, make arrangements directly with one of the Iowa community college testing sites. A proctor fee will be paid directly to the community college testing site.

☐ Enclose a notarized copy of your diploma from dental school.

☐ Complete and enclose the form "Authorization for Release of Personal Information."

☐ Forward the form "Certificate of Dental Education" to your dental school and request the completed form be submitted directly to the Board office.

☐ Include a notarized copy of your marriage certificate or divorce decree if the name on your application is different than the name on your diploma or other documents.

☐ Upon receipt of a completed application for licensure, the Iowa Board of Dental Examiners will mail you a packet of information necessary to perform a criminal history background check as required by Iowa Administrative Code 650—Chapter 11. *The Board will not issue licensure until you have returned the completed packet and fee for the criminal history background check to the Board office. Please make sure that the information and fingerprints you provide in the criminal history background check packet are legible. In the event, the fingerprints are illegible you may be required to have your fingerprints redone.*

☐ Include evidence of possessing a valid, current certificate in a nationally recognized course in cardiopulmonary resuscitation (such as a photocopy of the front and back of your current CPR card).

☐ Request a license certification from each state in which you have ever been licensed. Mail the enclosed form to each state and request that the certification be forwarded directly to the Board office. Please note that some states require a fee to process the enclosed form. (New graduates are exempt.)

☐ Submit a letter to the Board stating: a) the reason why you want to be licensed in Iowa; b) your practice plans; c) whether or not you dispense drugs as part of your practice; and d) whether or not your practice includes the administration of general anesthesia or conscious sedation. Please be specific as to your location, dental associates and the type of practice.

☐ Licensure by examination applicants: Enclose the non-refundable application fee of $100, made payable to Iowa Board of Dental Examiners.

☐ Licensure by credentials applicants: Enclose the non-refundable application fee of $275, made payable to Iowa Board of Dental Examiners.

APPLICATION FOR IOWA DENTAL LICENSE

IOWA BOARD OF DENTAL EXAMINERS

400 S.W. 8th Street, Suite D, Des Moines, Iowa 50309-4687
Ph. (515) 281-5157 http://www.state.ia.us/dentalboard

Please read the accompanying instructions prior to completing this application.

Application by: _____ Examination _____ Credentials

1. IDENTIFYING INFORMATION

Full Legal Name: (Last, First, Middle, Suffix)			
Other Names Used: (e.g. Maiden)			
Home Address:			**Telephone:**
City:	**County:**	**State:**	**Zip:**
Work Address:			**Telephone:**
City:	**County:**	**State:**	**Zip:**
Home Fax:	**Home E-mail:**	**Work Fax:**	**Work E-mail:**
Social Security Number:	Privacy Act Notice: Disclosure of your social security number on this license application is required by 42 U.S.C. section 666(a)(13) and Iowa Code section 252J.8(1). The number will be used in connection with the collection of child support obligations and as an internal means to accurately identify licensees.		
Height:	**Weight:**	**Hair Color:**	**Eye Color:**
Identifying Marks:	**U.S. Citizen?** ☐ Yes ☐ No	**If No, Visa Type or Alien Registration Number:**	
Date of Birth:	**City of Birth:**	**State of Birth:**	**Country of Birth:**
Father's Full Name:		**Mother's Full Name:**	
Full Name & Address of Nearest Relative Not Living With You:			

2. BASIS FOR APPLICATION

EXAMINATION	PASS	DATE(S):
National Board Examination (Attach original or a notarized copy of National Board card reflecting scores.)	☐ Passed	
Central Regional Dental Testing Service (CRDTS) (Attach scores from each examination attempt.) **Western Regional Examining Board (WREB)** If taken after 01/01/01 (Attach scores from each examination attempt.)	☐ Passed ☐ Passed	
Iowa Jurisprudence Examination (Required by every applicant.)	☐ Passed	
Other National, Regional, or State Licensure Examinations (List all other examinations taken. Include the date and scores.) _____	☐ Passed	

Office Use				
	Lic. #	Diploma	Fee	Cert. Ed
	Book# pg.	Nat'l Bd	Cert. Lic	Ref
	Date issued	Date approved	CRDTS	Juris
	Marriage Cert.	CPR	Fingerprints	

Name of Applicant _____

3. PRELIMINARY EDUCATION

Name of High School:	**City, State:**	**From (Mo, Yr):**	**To (Mo, Yr):**
Name of College:	**City, State:**	**From (Mo, Yr):**	**To (Mo, Yr):**
Name of College:	**City, State:**	**From (Mo, Yr):**	**To (Mo, Yr):**

4. DENTAL EDUCATION

Institution	City, State, Country	**From (Mo, Yr):**	**To (Mo, Yr):**
Year (1)			
Year (2)			
Year (3)			
Year (4)			
Degree Received:	**Date of Degree:**		

5. POST-GRADUATE DENTAL TRAINING

Institution:	**Specialty:**	**From (Mo, Yr):**	**To (Mo, Yr):**
Address:	**City:**	**State/Providence:**	

6. CHRONOLOGY OF ACTIVITIES

Provide a chronological listing of all dental and non-dental activities from the date of your graduation from dental school to the present date, with no more than a three (3) month gap in time. Include months, years, location (city & state), and type of practice. Attach additional sheets of paper, if necessary, labeled with your name and signed by you. Attach a practice reference for each practice location in the last three (3) years.

Activity & Location	From (Mo, Yr):	To (Mo, Yr):

7. LICENSE INFORMATION

List all state/countries in which you are or have ever been licensed.				
State/Country	**License No.**	**Date Issued**	**License Type (e.g. Resident, Faculty, Permanent)**	**How Obtained (e.g. Credentials, Exam)**

Name of Applicant _____

DEFINITIONS FOR SECTION 8.

Important! Read these definitions before completing the following questions.

"Ability to practice dentistry with reasonable skill and safety" means ALL of the following:

1. The cognitive capacity to make appropriate clinical diagnosis, exercise reasoned clinical judgments, and to learn and keep abreast of clinical developments;
2. The ability to communicate clinical judgments and information to patients and other health care providers; and
3. The capability to perform clinical tasks such as dental examinations and dental surgical procedures.

"Medical condition" means any physiological, mental, or psychological condition, impairment, or disorder, including drug addiction and alcoholism.

"Chemical substances" means alcohol, legal and illegal drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

"Currently" does not mean on the day of, or even in weeks or months preceding the completion of this application. Rather, it means recently enough so that the use of chemical substances or medical conditions may have an ongoing impact on the ability to function and practice, or has adversely affected the ability to function and practice within the past two (2) years.

"Improper use of drugs or other chemical substances" means ANY of the following:

1. The use of any controlled drug, legend drug, or other chemical substance for any purpose other than as directed by a licensed health care practitioner; and
2. The use of any substance, including but not limited to, petroleum products, adhesive products, nitrous oxide, and other chemical substances for mood enhancement.

"Illegal use of drugs or other chemical substances" means the manufacture, possession, distribution, or use of any drug or chemical substance prohibited by law.

SECTION 8. In answering each of the following questions, please check the appropriate box next to each question. **FOR EACH "YES" ANSWER TO QUESTIONS 1 THROUGH 22, YOU MUST PROVIDE A SEPARATE, SIGNED STATEMENT GIVING FULL DETAILS, INCLUDING DATE(S), LOCATION(S), ACTION(S), ORGANIZATION(S) OR PARTIES INVOLVED, AND SPECIFIC REASON(S).**

YES	NO	
☐	☐	1. Do you currently have a medical condition that in any way impairs or limits your ability to practice dentistry with reasonable skill and safety?
☐	☐	2. Are you currently engaged in the illegal or improper use of drugs or other chemical substances?
☐	☐	3. Do you currently use alcohol, drugs, or other chemical substances that would in any way impair or limit your ability to practice dentistry with reasonable skill and safety?
☐	☐	4. If YES to any of the above, are you receiving ongoing treatment or participation in a monitoring program that reduces or eliminates the limitations or impairments caused by either your medical condition or use of alcohol, drugs, or other chemical substances?
☐	☐	5. If YES to any of the above, does your field of practice, the setting, or the manner in which you have been chosen to practice dentistry, reduce or eliminate the limitations or impairments caused by either your medical condition or use of alcohol, drugs, or other chemical substances?
☐	☐	6. Have you ever been charged, convicted, found guilty of, or entered a plea of guilty or no contest to a felony or misdemeanor crime (other than minor traffic violations with fines under $100)?
☐	☐	7. Have you ever been terminated or requested to withdraw from any dental school or training program?
☐	☐	8. Have you ever been requested to repeat a portion of any professional training program/school?
☐	☐	9. Have you ever received a warning, reprimand, or been placed on probation during a professional training program/school?
☐	☐	10. Have you ever been denied a license to practice dentistry?
☐	☐	11. Have you ever voluntarily surrendered a license issued to you by any professional licensing agency?
☐	☐	11a. If yes, was a license disciplinary action pending against you, or were you under investigation by a licensing agency at that time the voluntary surrender of license was tendered?

Name of Applicant _____

YES	NO		
☐	☐	12.	Have you ever been denied a Drug Enforcement Administration(DEA) or state controlled substance registration certificate?
☐	☐	13.	Have you ever surrendered your state or federal controlled substance registration or had it restricted in any way?
☐	☐	14.	Aside from ordinary initial requirements of proctorship, have your clinical activities ever been limited, suspended, revoked, not renewed, voluntarily relinquished, or subject to other disciplinary or probationary conditions?
☐	☐	15.	Have you ever been terminated, sanctioned, penalized, had to repay monies to, or been denied provider participation in any state Medicaid, federal Medicare, or other publicly funded health care program?
☐	☐	16.	Are any malpractice claims or complaints in process/pending against you?
☐	☐	17.	Have any settlement agreements been rendered or any judgments entered against you resulting from your practice of dentistry?
☐	☐	18.	Are charges or an investigation currently pending relative to your dental license in any other state?
☐	☐	19.	Has any jurisdiction of the United States or other nation ever limited, restricted, warned, censured, placed on probation, suspended, or revoked a license you held?
☐	☐	20.	Have you ever been notified of any charges filed against you by a licensing or disciplinary agency of any jurisdiction of the U.S. or other nation?
☐	☐	21.	Do you have professional liability suits in process or pending?
☐	☐	22.	Have any judgments or settlements been paid on your behalf as a result of a professional liability case(s)?
☐	☐	23.	Do you understand that if a license is granted by this board, it will be based in part on the truth of the statements contained herein, which, if false, may subject you to criminal prosecution and revocation of the license?

9. AFFIDAVIT OF APPLICANT

STATE OF _____ COUNTY OF _____

I, _____, hereby declare under penalty of perjury that I am the person described and identified in this application and that the attached photograph is a true likeness of myself. I also declare that I am the lawful holder of the enclosed diploma, which was procured in the regular course of instruction and examination without fraud or misrepresentation.

I further state that I have read the statutes and rules pertaining to the practice of dentistry as prescribed in Iowa Code chapters 147, 153, and 272C and 650 Iowa Administrative Code. If a license to practice dentistry is issued to me, I understand that if I violate any laws or rules, my license may be revoked as provided by law.

I declare, under penalty of perjury, that my answers and all statements made by me on this application and accompanying attachments are true and correct. Should I furnish any false information, or have substantial omission, I hereby agree that such act shall constitute cause for denial, suspension, or revocation of my license. I also declare under penalty of perjury that if I did not personally complete the foregoing application that I have fully read and confirmed each question and accompanying answer, and take full responsibility for all answers contained in this application.

I hereby agree to abide by the laws and rules pertaining to the practice of dentistry in the state of Iowa.

Signature of Applicant _____

Sworn to before me this _____ day of _____ , _____

Signature of Notary Public _____

NOTARY SEAL

ATTACH CURRENT PHOTOGRAPH HERE

AUTHORIZATION FOR RELEASE OF PERSONAL INFORMATION

I _____ do hereby authorize a full disclosure of all records concerning myself to any duly authorized agent of the Iowa Board of Dental Examiners, whether the said records are of a public, private, or confidential nature.

The intent of this authorization is to give my consent for full and complete disclosure of records of state, territorial, or national dental licensing agencies or boards, educational institutions, medical and psychiatric treatment and/or consultation, including hospitals, clinics, private practitioners, and the U.S. Veterans Administration, employment and pre-employment records including background reports, efficiency ratings, complaints or grievances filed by or against me and records of any actions either criminal or civil, in which I presently have, or have had involvement, including arrest, criminal history, and motor vehicle driving records. This release also includes information concerning hospital staff membership or privileges, residency records as well as records of hospitals, clinics, private dental offices, attorneys and insurance companies regarding professional liability or malpractice claims and/or lawsuits.

I understand that any information obtained by a personal history background investigation, which is developed directly or indirectly, in whole or in part, upon this authorization for release will be considered in determining my suitability for a license to practice in the State of Iowa. I also certify that any person(s) who may furnish such information concerning me shall not be held accountable for giving this information; and I do hereby release said person(s) from any and all liability which may be incurred as a result of furnishing such information. I further release the Iowa Board of Dental Examiners from any and all liability, which may be incurred as a result of collecting such information.

A photocopy of this release form will be valid as an original thereof, even though the said photocopy does not contain an original writing of my signature.

This authorization for release is non-expiring and shall continue in force and effect indefinitely.

I have read and fully understand the contents of the "Authorization for Release of Personal Information."

_____ _____

Signature of Applicant Date

_____ _____

Signature of Witness Date

CERTIFICATION OF EDUCATION

As part of the license application process, the Iowa Board of Dental Examiners requires that the school at which the applicant received her/his dental or dental hygiene education complete this form. The completed form must be mailed directly from the school to the **IOWA BOARD OF DENTAL EXAMINERS.** Any processing fees are the applicant's responsibility. The applicant's signature authorizes release of information, favorable or otherwise, directly to the Board.

Print Name_____ **SS#**_____

Signature_____ **Date**_____

****

This portion of the form should be completed by the school.

IT IS HEREBY CERTIFIED THAT _____
(Name of Applicant)

RECEIVED DENTAL/DENTAL HYGIENE EDUCATION AT_____
(Circle One) **(Name of School)**

LOCATED AT_____
(Full Address of School)

FROM_____**TO**_____
(Month/Year) **(Month/Year)**

GRANTED A DIPLOMA WITH THE DEGREE OF_____

DATE DIPLOMA RECEIVED_____
(Month/Year)

Was the school accredited by the Commission on Dental Accreditation of the American Dental Association at the time the applicant graduated? Yes_____ **No**_____

President, Dean, Secretary, or Registrar:

SCHOOL SEAL

Print Name_____ **Title**_____

Signature_____ **Date**_____

Phone #_____ **Fax #**_____

Return Completed Form to:
IOWA BOARD OF DENTAL EXAMINERS
400 S.W. 8th St, Suite D
Des Moines, IA 50309-4687
Phone (515) 281-5157

CERTIFICATION OF LICENSURE

As part of the license application process, the Iowa Board of Dental Examiners requires that this form be completed by every board that has ever issued any license to the applicant, even if the license is not current. The completed form must be mailed directly from the state licensing board to the **IOWA BOARD OF DENTAL EXAMINERS.** Any processing fees are the applicant's responsibility. The applicant's signature authorizes release of information, favorable or otherwise, directly to the Board.

Print Name_____ **License #**_____

Signature_____ **Date**_____

****

This portion of the form should be completed by the state licensing board.

IT IS HEREBY CERTIFIED THAT _____
(Name of Applicant)

WAS GRANTED LICENSE NUMBER_____ **DATE ISSUED**_____

TO PRACTICE_____ **IN THE STATE OF**_____

DATE LICENSE EXPIRES_____ **LICENSE STATUS**_____

BASIS FOR LICENSURE:

- ☐ **NATIONAL BOARD EXAM**
- ☐ **ENDORSEMENT/RECIPROCITY**
- ☐ **STATE BOARD PREPARED WRITTEN AND/OR PRACTICAL EXAM**
- ☐ **REGIONAL CLINICAL EXAM, NAME OF TESTING AGENCY**_____

☐ **Scores are recorded as follows:**

SUBJECT	PERCENT	SUBJECT	PERCENT
_____		_____	
_____		_____	
_____		_____	

☐ **Scores are no longer available, however, I certify that it is apparent the applicant received a score sufficient to meet the licensure requirements of this state at that time; and these requirements were substantially equivalent to the requirements for licensure in Iowa.**

☐ **YES** ☐ **NO** **Disciplinary action ever been initiated, pending, or taken?**

STATE OR BOARD SEAL

Print Name_____ **Title**_____

Signature_____ **Date**_____

Phone #_____ **Fax #**_____

Return completed form to: IOWA BOARD OF DENTAL EXAMINERS
400 S.W. 8th St, Suite D
Des Moines, IA 50309-4687
Phone (515) 281-5157